Kentucky Lung Cancer Research Program
Governance Board - Meeting Minutes, May 7, 2012

In attendance: Members: Harry Carloss (Chair)*, John Eaton (UofL)*, Mark Evers (UK)*, Joe Graviss (CPE)*, Don Miller (UofL)*, Tim Mullett (UK)*; Guests: Kris Damron (KCTN), Diane Konzen (UofL), Milton Pierson (UofL), Nathan Vanderford (UK), Beth Yost (UK), and Linda Linville (CPE staff).

Harry Carloss, Chair, called the meeting of the Kentucky Lung Cancer Research Program Governance Board (GB) to order at 1:00 PM, May 7, 2012 with six members* and six guests in attendance. A quorum was determined.

Past minutes of the January 27, 2011 and September 28, 2011 meetings were approved as delivered to members electronically. (Motion to approve by Dr. Miller, seconded by Dr. Mullett).

Funding Process: Dr. Carloss explained Tobacco Settlement funding and the determination of contested appeals by states to national tobacco companies, not party to the Settlement. Dr. Carloss stated clearly that the GB has no governance over the ovarian funds deducted from the tobacco settlement funds provided to the University of Kentucky Ovarian Cancer Screening Program. If these funds have any impact on the Comprehensive Cancer Center applications, then perhaps use of such funds for ovarian screening could be contested. Dr. Miller asked about the rationale for diminishing funds, suggesting such reduction may be the effect of fewer persons smoking. Dr. Carloss explained his understanding that some tobacco companies had not been a part of the settlement agreement originally and their role is now being contested. As time has passed, the larger tobacco companies are challenging smaller companies to take on some of the settlement responsibilities. Reduction of funds is likely also attributed to the economy and investments of settlement funds.

REVIEW OF ANNUAL REPORTS:

Nathan Vanderford reported on the University of Kentucky's annual outcomes as related to the Goals of the program.

1. Investigator Initiated Research: In the last FY, there were 17 active projects, 30 new research faculty, three of which have specific lung cancer interests, 20 grant submissions with five new awards being funded.

2. Research in Early Detection & Prevention – Driesler study continues, as reported at last meeting, i.e. a study of lung cancer in specific geographic locations, with specimens contributed to the tissue bank from more than 100 participants.

3. The Kentucky Clinical Trials Network (KCTN) includes expansion into sites in every congressional district, with 70 0f 120 counties reporting patient accrual. 421 patients were enrolled at the end of 2011. Site development achievements are sited in report (as attached) and as required for COC accommodations. KCTN was able to on-board two new site teams continuing 1:1 mentoring/training for research nurses, including a 10-week course for all nursing coordinators. KCTN researchers have

participated in 23 pharmaceutical trials, some of which are international. Two innovative CTs at KCTN sites are included in the reporting template as spotlighted by director, Kris Damron. - a Dexamethasone trial and trial findings 1650G vaccine trials, as being completed or near analysis completion. Some patients are continuing on survivor follow-up status. Staff continues the central development of sponsors for II-trials. Kris shared a testimonial by Dr. Rheinhart who recognizes KCTN's involvement in his investigations. Portfolio recognition included operations' improvement with 25 visits/quarter to sites. Additional testimonials regarding community-generated research unique to the population served are being received, a tribute to the work of KCTN researchers and staff.

Dr. Mullett highlighted a trial currently under development, a Stereotactic Radiology Trial, based at UofL. Ron McGary at UK, radiologist with a technique to improve stereotactic capacity is partnering with the UofL researchers Dr. Kloecker and Woo**.** This trial will highlight Kentucky's involvement and will bring additional funding opportunities, as well as screening tools to bear.

4. NCI designation was reported by Dr. Evers. Through a cancer center Support Grant over the last 3 years, 30 new faculty members have been recruited, with programs and shared resources to support the Center. Analysis of programmatic interactions indicates 15% grants are interactive within the center. The Markey Center boasts a current rate of 10% of total cancer patients enrolled in CTs, with over a 20% enrollment of lung cancer patients.

In addition to program grants, the KCTN is supporting additional cancer center staff. NCI designation program funds support administrative and business officer personnel. In FY 2011, Markey's research coordinator position was vacated, and is now supported by the Driesler grant. $225K was spent on salaries within the cancer center.

Investigator-Initiated grants list active grants in both Cycle 9 and 10 with carry-over funding of $752K.

Dr. Linville inquired about the challenges that the centers face in reaching the goals of the intended program and how these challenges are being revised in any way to reach the outcomes desired and as stated in the Strategic Plan. Nathan responded that strategic recruitment of lung cancer researchers to assist in basic research, interaction within the Center, and eventual assistance with translational research is a definite strategy.

UofL Annual Report:

1. Investigator Initiated Research: Dr. Miller's recruitment of existing faculty over last 18 months with pilot grants to bring new plant-based, drug development researchers is a priority for this KLCRP goal. Dr. Miller and staff continue the recruitment efforts for a new director of medical oncology, looking for applicants with interest in lung cancer for which UofL has an endowed chair. Currently UofL has 10 active research grants, awarded 5 of 20 in Cycle 10, and many received an increased number of proposals for Cycle 11 funds. Drug development research is funded by KLCRP and near entry into Phase I trials is expected in December, 2012. UofL has used KCLRP funds for Phase I research as

well. Under P01 review currently is metabolic research funded by KCLCP, and another is in the process. These studies have potential for huge impact within the oncology community.

2. Research in Early Detection and Prevention – UofL has funded a Manhattan project to develop early detection mechanisms utilizing breath analysis discovery and is engaging UK to collect samples from patients having CT scans to move such screening forward quickly. The bio-repository is growing having procured over 100 specimens. Partnerships and CT negotiations are currently underway with Owensboro and Campbellsville oncology providers. Early detection research over the next year credits KCTN with such negotiations.
3. NCI designation – UofL continues to work through recruitment and funding of research. Of prominent importance is to seek new scientists with lung cancer interest/expertise.

Milton Pierson reported the fiscal ROI as the use of funds form KLCRP with 10 active trials, and administrative salaries of nurses and physicians working in lung cancer. Core facility staff is partially supported by KLCRP, with tissue repository and spectroscopy efforts, in addition to several administrative staff positions.

NCI designation also supports fellows. Detailed Cycle 9, 10, and 11 research support is provided in the annual report and is running smoothly. $462K has been expended, with annual $2.03M to support research programs.

Annual reporting timelines. Dr. Linville explained the proposed timeline based on Purchase Order (PO) Agreements with institutional responsibilities conveyed. The reporting template should be prepared for plan of the institutional/collaborative programs with anticipated/expected goal-oriented outcomes and incorporate any timeline revisions annually. The Council (CPE) expects budget requests annually and timely reporting of both program and fiscal activities. An expressed interest in pushing annual reporting to September 15 was agreed by all. CPE does not require quarterly reports similar to those sent to the Healthcare Improvement Board which has indicated that the report submitted to CPE is also sufficient for their purposes. CPE Agreements require a comprehensive annual report with semi-annual financials only. Noted by the GB was the large amount of carry-forward funds with a request for explanation and plan for use of these funds. Milton indicated the need to reserve recruitment funds reserved. It was noted that this particular challenge was not noted in the annual reports as requested.

The timeline for release of RFP's was agreed to be added to the calendar for August with sufficient time for tardy reviewers and competitive federal funding cycles to clear in order to review and return all documents to determine awards and make recommendations to the GB in February. Invoicing for these funds could then occur in March of each year, and be prepared for funding revenues to be received by CPE and rapidly disbursed. The reporting timeline will now include specific dates for grant proposals to be solicited and reviewed by the GB.

Dr. Evers expressed concern if timely reporting was not occurring. Dr. Linville indicated that standardized reporting as recommended by and between CPE and cancer center staff had been lacking, thus the agenda item for discussion. There is confusion by many, including members of the GB regarding receipt of funds by CPE, then disbursement late in each FY. However, this is the manner and

policy that CPE has followed given receipt of settlement funds by the states does not occur until late spring each year. Dr. Linville reported that the FY11-12 funds had not been received yet. Often changes in AGREEMENTS take place just prior to receipt of funds causing undue work on the part of administrators, but such adjustments are mandated by the state budget office with no prior notification to CPE.

Budget Requests have not previously been submitted to CPE, perhaps the institutions have submitted to their own budget offices, but not to CPE. Dianne Konzen recalled having submitted such to CPE, but previous submissions of budgets to CPE have only involved preference as to how to split the grant and administrative funds, not intent or planned use of the funds in a succeeding year. A budget request should reflect institutions intended use of funds in the categories as expressed by the goals of the Strategic Plan. CPE does not currently receive that information. Dr. Miller indicated his need to know what was requested and his center would comply with such. Perhaps the centers are reporting this information to their sponsored program offices, but not to CPE.

Dr. Linville will provide a revised timeline for all with specific dates for budget requests, funding recommendations, annual reporting, et al. The detail of such reporting has been requested in the past, a template for that reporting provided, but minimal compliance with those requests. Use of the developed template for reporting is also a tool for budget requests. Review of annual reports can then compare requests to actual expenditures and activities. CPE representative, Mr. Graviss, indicated that he had contributed to this work and Dr. Carloss was in agreement that consensus on reporting and expectations of time, and reporting content would be determined during this GB meeting. It was thus agreed to keep three meetings of the GB, one in October to review annual reports, one in February to review II-grant proposals and recommendations for funding, and May to review CPE/institutional Agreements (only on biennial basis).

Strategic Plan Revisions: Dr. Linville reiterated the need for strong objectives to meet the intention of the funding to Kentucky as we head into the last eight and final years of Settlement funds. Dr. Carloss indicated that the KLCRP needed a compelling reason to continue funding, with a ground swell of support to continue. Dependence on activities/research is needed to eradicate this disease if there is to be sustained funding after 2020.

The regulation establishing the KLCPR calls for the Strategic Plan to be reviewed biennially. UK submitted a Strategic Plan which they prepared, and requested comment from UofL. The GB approved the UK submitted plan, but encouraging both institutions to make such review/revision a part of their institutional annual reports, noting any changes in goal setting, objectives, and/or outcome metrics. Such review will be added to the timeline for discussion during the GB's February meeting with revisions due at the May meeting. Dr. Mullett noted and suggested use of the model used by the colon cancer screening program that follows the science in the development of the disease to inform revisions to a strategic plan. Dr. Mullett further indicated that statewide support has to come from screening. The Lung Cancer (LC) screening trial is strong and needs support. LC screening is now approved by payment by some insurance companies. Scientists know that the main issue is false-negative (F/+) results; knowing this addresses a priority for lung cancer research and one in which the KLCRP should be

involved. This is an exemplary cause to revise the program's strategic plan to address this needed research. Dr. Mullett also indicated the need to work as team, as not doing so does reduces the program's credibility. KCTN was developed just for this type of work and could and should move the research findings and agenda forward with early detection trials.

In further timeline discussions, Beth Yost indicated a problem with invoicing in April if, as in recent years, budget cuts often occur at this time. This being true, the budget office is the determining agency – if invoicing occurs prior to cuts being know, the disbursement figures are the cut figures and permissible. It is the determination of where the cuts will occur that presents problems for CPE, as the GB determines how the cuts are to be taken – i.e. in the grants portion or in the administration portion of the funds. In previous years $1.5M has always been reserved for grants. This year, the cuts have been requested by the cancer centers to be taken at UK from the grants portion and at UofL from the administration portion of the funding.

Dr. Linville is requested to update the reporting calendar and agenda for meetings as adherence to the Agreements and the intent of the legislation is vital to the program's integrity. A standing agenda will be included with additional items included as "other business". A draft and call for such will be sent as notification to all GB members prior to the three meetings each year.

Both Drs. Evers and Miller agree that they need to know what is needed/expected and will comply. Mr. Graviss motioned to accept concept of set agendas/timeline with dates with further explanation provided if needed. Such documents will reflect responsibilities of the institutions as stated in the Purchase Orders (Agreements).

<u>Review of Program Discussion</u>: Dr. Carloss indicated that for several years the topic of a complete program review of KLCRP had been discussed, but no action taken. He would like to see a review of the body of work over the past 12 years. A discussion followed about what to review, which would be responsible for the review, how to fund such a review, etc. Many ideas surfaced with regard to a retrospective study, with recommendations for what specific historical data to include in planning for the remaining years of funding. One suggestion was to have a one day or less meeting to hear presentations regarding the science around lung cancer, challenges for research, with suggestions with direction of remaining funding period. Other suggestion was to include other tobacco settlement states to comment on their success to date as relates to use of funds for lung cancer research. Mr. Graviss indicate an estimated $32M had been expended to date and yet we had no metrics/substantial outcomes data to share. Dr. Miller indicated that prior to the funding there were no set-aside funds for lung cancer research, but now UofL boasts ~19 lung cancer researchers that will make a difference for the people of Kentucky. Mr. Graviss wants data to answer the questions surrounding what we know about lung cancer and how we diagnose it and treat it. *Is there a consensus, that's good. If we have 20% of patients on CT, then that's good. What's a best practice? Is it happening?* Have there been any Phase I trials instigated by KLCRP seed funding? Partial unknowns of the program are the program's lack of communication with outside world. Members indicated the improvement to care that will come from patients enrolled in trials, as provided by one of the initial vaccine determinants in the nation being a Kentucky discovery. KCTN has had multiple press releases about its work. The program as a whole has

had none. Press coverage must focus on the work giving credit to the program. A question was posed regarding the Healthcare Improvement Board's release of outcomes from the total tobacco settlement. Dr. Miller indicated that he speaks to the health and welfare legislative body regularly and they appear content with the program reported to them. Drs. Carloss and Mullett indicated that public pressure is helpful in supporting work done by research funds and tobacco companies, so there is a need to shine this light. Dr. Miller questions if this was the responsibility of the GB. He also indicated that both institutions should be able to come up with some reportable KLCRP success stories.

Mr. Graviss indicated that external reviewers would be able to provide such highlights, but only if given direction and in close communication with directors and GB members. He suggested that the GB determine the end product of a review and how best to convey the work to audiences of interest (legislators/public/health care providers/patients). GB needs to determine questions/insights we are seeking as scope of work for a reviewer, not pre-determined outcomes. First must be determined what to review, a report of the big picture, with the institutions adding details of report. Perhaps strides toward goals and outcome metrics could be presented as well? A meaningful report with data useful for revisions to goals is needed. Strategic plan should inform any reviewers and should be addressed as a starting point. Accomplishments of the entire program's results are needed, not just institutional reports. Address collaborative work and the 20% required by regulation – is this being met? Defining collaborative work may need definition. Although KCTN is 16% of the funding does the work of the two institutions reflect 20% collaboration and how might this be determined? A desired outcome would be to use KLCRP as model for state research collaborations – a huge bonus to continue funding, and void of duplication.

Next steps with regard to program review are to gather accomplishments with more questions: identify a review mechanism (graduate student, RFP for external reviewer, site visit, other possibilities). A credible review process and due date determination should be the GB's focus for October meeting. Dr. Evers emphasized importance of seeking translational funding and this program is important to do so, along with publications and carry-on funding from KLCRP seed research funding.

ACTION ITEM: By next board meeting, OCTOBER 2012 – provide determinants of full review of the program.

Dr. Arnold's screening trial update. Driesler project findings are similar to NEJM article reported when GB last met. What recommendations could GB/Cancer Centers actively support? Should the GB designate funding to such a screening program? UofL is concerned about the high rate of F/+ findings in the program. Is this challenge being met via KLCRP funded research? Kris Damron reported that KCTN researchers are working on concept development to improve F/+, but also biomarker, radiologist education, and the community aspect of such a study. NCCN supports lung cancer screening, but how to implement the educational component for community radiologists remains a challenge. Dr. Mullett indicated that science supports the screening project, but we must participate! It's more than just an advisement, attention to the issue with essential staffing and data systems must be brought to reality. KLCRP has such funds and must support science on such a program. This translation of applying the known science is vital. Dr. Carloss supports the science-based screening for lung cancer and clarified Dr. Mullett' suggested proposal that the GB work to have a funded screening project to include a

coordinator, data base system to capture data from screened patients. Such a recommendation would require an externally reviewed and recommendation to the GB for funding. Sputum banks could also offer additional opportunity for research. Dr. Mullett will put forth such project proposals. Kentucky should support such efforts similar to colon cancer screening, perhaps a separate line item for this work. Although it may be difficult to take such funding out of existing funds, it is certainly within the scope and intent of the funding. Dr. Mullett reported that the F/+ findings must be studied further with recommendations for appropriate patient follow-up. He also shared a national study conducted with 3000 patients which includes any/all risk associated variables with F/+. Further and supported research would assist in finding these determinants teased out from the original CT scan findings. Survival rates will improve if these findings prove to be statistically significant. Dr. Carloss addressed the justification for a pilot program to track scientific soundness of screening, with study of F/+ results and tracking, pay for it out of GB money with reasonable expectations of results, then seek external funders. Monies saved with Medicaid, etc. will need to address cost benefit. Dr. Mullett motioned that the next cycle of II funding be focused on screening and early detection through a common project using KCTN as launching pad for screening and infrastructure with additional trials to come to KCTN of breath analysis or other assessments. Both institutions should determine costs/who/what/how to fund, etc. Dr. Evers suggested such a study limit its scope to a specific high incidence area of the state. Dr. Carloss will work to instigate state support for such a statewide screening endeavor, with data to support where the work might focus its efforts geographically. This would be exemplary of identifying a research need and actively pursuing translation of the science for further study.

Dr. Miller indicated that UofL is pushing ahead with current work and will continue to work on a pilot program. Taking a year's budget is risk of current investments but Dr. Mullett indicated that perhaps not the entire II funding reserve would be needed.

ACTION ITEM: Dr. Mullet will prepare project recommendation with proposed budget with input from Drs. Evers and Miller as related to current related and anticipated work (i.e. sputum analysis, breath analysis, et al) and present at October GB meeting for review.

Nathan Vanderford pointed out that an investigator was needed to lead the work. Dr. Mullett and his colleagues would qualify as PI(s). Noted was the need to engage external peer reviewers as vital to the integrity of the program.

Funding scenarios – When presented with the current budget reduction scenarios, UK's decision was is to take cut from grant pool of $750,000. UofL requested their cut across the board, an equal percentage from both grant and administrative funds.

	Appropriation	Cut (5.28%)	FY 11-12 Funds
UK Grants	$ 750,000	$ 115,015	$ 634,985
UK Admin	$ 1,428,308	$ -	$ 1,428,308
UofL Grants	$ 750,000	$ 39,600	$ 710,400
UofL Admin	$ 1,034,292	$ 54,611	$ 979,681
	$ 3,962,600	$ 209,225	$ 3,753,375

II Grant Recommendations: UofL received 21 applications, selected four, one of which is for partial funding. UK submitted recommendations for five proposals. UK 's recommendations are the result of emphasis on SPORE mechanism submissions between the PI and research team. This stipulation of proposals is to continue, adding to specific shared resources of CORES. UK received 20 applications, recommended five with a sixth project for partial funding. The last project relates work being conducted on chemotherapy treatment effects on normal tissue project.

Dr. Miller motioned for acceptance of proposals, Dr. Eaton seconded the motion. Motion passed.

University of Louisville KLCRP Recommended Proposals		
Approved for Funding May 7, 2012		
PI	Title	Funding
Wattenberg, Brian	Targeting Sphingolipid Metabolism for the Treatment of Lung Cancer	$ 150,000
Yaddanapudi, Kavitha	New Approaches for Eliminating Lung Cancer Initiang Stem Cells	$ 150,000
Yong, Li	The Role of mi201a in NFkappaB Activatin and Lung Cancer	$ 150,000
Li, Chi	Activating Bax as a Therapeutic Strategy Against Lung Cancer	$ 73,344

University of Kentucky KLCRP Recommended Proposals		
PI	Title	Funding
Orren, David		$ 100,000
Hopenhayn, Claudia		$ 75,000
Vore, Mary		$ 100,000
Yang, Lin		$ 75,000
Li, Guo-Min		$ 100,000
St. Clair, Daret	Mechanisms of Chemotherapy-Induces Tissue Injury	$ 73,344

Mr. Graviss questioned how the grantees' work was being evaluated and if it were being reviewed as aligned with goals of the Strategic Plan. He asked if second year of funding for researchers was predicated on any 1st year success. Dr. Miller indicated that assurances from the institutions as to promising work of researchers was the expected responsibilities of each institution with second year of funding predicated on first year benchmarks. Questions arose as to any success with externally-funded research as a result of these seed funds, and should this be reportable to the GB. Dr. Miller indicated that what he expected to see were results such as publications and addition funding to carry the research forward, but on a year-to-year basis such evaluation may be difficult to identify. Dr. Evers indicated that he kept researchers' committed requiring evidence of success. Nathan Vanderford indicated that research success is tracked at the institution with recorded publications, successive

grants, et al. It was concluded that the annual reports would include a summary of outcomes at the end of a funded project with a checklist of first year researchers' adherence to research as proposed and center directors' assurances of same. Further inquiries related to the end of any research prior to utilization of full funding and how this was to be handled. Beth Yost indicated that funds were kept in separate accounts and any balances pooled as carry-forward to future projects. The discussion regarding "research success" and how to determine continued funding was also on the radar of the institutions with current discussion as to how best to determine success and continued funding approvals. A motion was passed to require institutional assurances be provided to the GB related to continued funding per award timelines.

There being no further business, the meeting adjourned at 3:20 PM.

LL - Submitted for review 5/18/12.